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# Insurance

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# INSURANCE

WILLIAM B. HARVEY

INTEREST and activity of both legislatures and courts in insurance problems continued strong during the past year. As usual, most of the new legislation related to minor technical and administrative matters. In New York, where the bottleneck on compulsory automobile liability insurance may yet be broken, the Dewey-backed bill passed easily in the Assembly<sup>1</sup> but bipartisan opposition was able to defeat it in the Senate by a narrow margin.<sup>2</sup> Compulsory-insurance bills were also introduced in Kentucky, Maryland, Michigan, Mississippi, South Carolina,<sup>3</sup> and New Jersey<sup>4</sup> but none was passed. Although his power to subpoena the records of union welfare funds received judicial approval without explicit legislative authorization,<sup>5</sup> the New York State Superintendent of Insurance sought and obtained such authorization.<sup>6</sup> Abuses revealed in the ensuing investigation<sup>7</sup> seem to warrant a continuing scrutiny of the administration of such funds by state or federal agencies. In the Congress, the administration's health reinsurance plan was stopped at least temporarily by recommitment to committee in the House of Representatives.<sup>8</sup> By far the most significant legislative accomplishment of the year was the enactment of the new social security law.<sup>9</sup> On September 1, at a Rocky Mountain ranch, while an ex-President and a dozen sirloin steaks waited, the President signed a bill bringing approximately ten million more persons under the social security system and enlarging the benefits of many others.<sup>10</sup> *Tempora mutantur.*

*National Service Life Insurance.*—In actions against the United States to recover special dividends declared on National Service Life Insurance policies, two federal district courts had occasion to determine whether the Government was entitled to reimbursement of amounts paid, pursuant to the Soldiers' and Sailors' Civil Relief Act of 1940,<sup>11</sup>

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<sup>1</sup> N.Y. Times, March 17, 1954, p. 1, col. 5.

<sup>2</sup> Id., March 20, 1954, p. 1, col. 4.

<sup>3</sup> Ins. L.J., March 1954, pp. 149-50.

<sup>4</sup> Ins. L.J., April 1954, pp. 229-30.

<sup>5</sup> Matter of Townsend, 206 Misc. 619, 130 N.Y.S.2d 327 (Sup. Ct. 1954).

<sup>6</sup> N.Y. Ins. Law § 28(3).

<sup>7</sup> Id., Sept. 10, 1954, p. 1, col. 4; id., Sept. 17, 1954, p. 1, col. 1.

<sup>8</sup> Ins. L.J., Aug. 1954, p. 517.

<sup>9</sup> Pub. L. No. 761, 83d Cong., 2d Sess. (Sept. 1, 1954), 68 Stat. 1052, 42 U.S.C.A. § 409(g)(2) (Supp. 1954).

<sup>10</sup> N.Y. Times, Sept. 2, 1954, p. 1, col. 5.

<sup>11</sup> 54 Stat. 1183 (1940), as amended, 50 U.S.C. App. § 501 (1952).

to keep in force the private life insurance of military personnel. In line with two earlier decisions,<sup>12</sup> *Plesha v. United States*<sup>13</sup> held that former servicemen were obligated to reimburse the United States for such payments. The case also held that this obligation could be set off against dividends declared on the servicemen's National Service Life Insurance. *Hormel v. United States*<sup>14</sup> held that no obligation to reimburse the Government was created by the 1940 Act, and the set-off question was therefore not reached. The *Hormel* decision, while concluding that Congress in passing the 1940 Act did not intend to confer the antilapse protection free of charge, refused to find an obligation to reimburse the Government on the ground that the Act did not provide a method for computing the amount of the liability.

*Rights of Loss Payee.*—In *Provident Fire Insurance Co. v. Union Trust Corp.*,<sup>15</sup> defendant had insured a truck against physical damage from a number of causes. A clause in the policy made any loss payable to the insured and plaintiff, assignee of the conditional sales contract covering the truck. The policy also provided that in the event the insured and insurer failed to agree upon the amount of loss, each should appoint "a competent and disinterested appraiser" to fix the amount. After a loss occurred, the insured, without the consent of plaintiff, settled with and released the insurer in consideration of an amount less than half of the repair estimate made by the original vendor of the truck and defendant's adjuster. Plaintiff refused to accept drafts issued by the insurer pursuant to the settlement and sued to recover the full amount of its lien. The Supreme Court of Appeals of Virginia held that plaintiff was bound by the loss determination and settlement on the ground that under the "loss payable" clause plaintiff's rights were purely derivative from the insured. The court also relied on the appraisal provisions of the policy as indicative of an intention that plaintiff should have no part in determining the amount of loss and settlement. The appraisal clause hardly justifies the result, however, since the difference between loss-fixing by the insured and insurer and by "competent and disinterested" appraisers appointed by them seems obvious and substantial.

The Supreme Court of Kansas considered the nature of the rights created by a "loss payable" clause in *Koenke v. Iowa Home Mutual*

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<sup>12</sup> *United States v. Nichols*, 105 F. Supp. 543 (N.D. Iowa 1952), appeal dismissed, 202 F.2d 958 (8th Cir. 1953); *Morton v. United States*, 113 F. Supp. 496 (E.D.N.Y. 1953).

<sup>13</sup> 123 F. Supp. 593 (N.D. Cal. 1953).

<sup>14</sup> 123 F. Supp. 806 (S.D.N.Y. 1954).

<sup>15</sup> 195 Va. 415, 78 S.E.2d 584 (1953), 40 Va. L. Rev. 234 (1954), 2 Wm. & Mary Intramural L. Rev. 50 (1954).

*Casualty Co.*<sup>16</sup> Hansen had lent Koenke money with which to purchase an automobile, the loan being secured by a chattel mortgage on the car. Hansen paid the premium on a policy of insurance issued by defendant to Koenke, and a few days after issuance defendant placed on the policy an indorsement making loss thereunder payable to Koenke and Hansen as their interests may appear. Koenke subsequently borrowed money from a loan company, giving chattel mortgages on the automobile, none of which was ever declared in the policy issued by defendant. Thereafter he defaulted in his payments to Hansen who took possession of the automobile and kept it until it was destroyed by fire. Defendant insurer relied on a clause of the policy providing that it should not apply while the automobile was subject to any mortgage not specifically declared and described in the policy. The court affirmed a judgment for Koenke and Hansen, declaring that even if it were conceded that Koenke's execution of the mortgages to the loan company avoided the policy as to him, the insurer had no defense against Hansen whose interest in the automobile was insured by the "loss payable" indorsement. Insofar as the opinion reveals, the court was unaware that its decision virtually erased the supposedly clear distinction between an open- and a union-mortgage clause.

*Insurable Interest for Liability Insurance.*—An unfortunate decision was handed down by the Court of Appeals for the Eighth Circuit in *Bettinger v. Northwestern National Casualty Co.*<sup>17</sup> Marie Bettinger purchased an automobile on August 11, 1951, and on August 14 the insurer issued a policy covering collision and upset losses as well as liability arising out of the ownership, maintenance, or use of the automobile on the part of Mrs. Bettinger and persons using the car with her permission. On August 22, 1951, Mrs. Bettinger transferred title to the automobile to her son, who, while driving it on October 26, collided with another car and injured two passengers in the latter vehicle. They brought suit against Mrs. Bettinger and her son, alleging that Mrs. Bettinger owned the car and that it was being operated with her consent. A Minnesota statute made the alleged facts conclusive of an agency relation between the owner and operator. The insurer declined to defend the action on the grounds that Mrs. Bettinger was not the owner of the automobile at the time the policy was issued, that her statement of ownership was a misrepresentation, and that by reason of the transfer of title to her son, Mrs. Bettinger had no insurable interest in the car at the time of the accident. The personal injury action resulted in substantial judgments against both defendants. The instant action was brought by the insurer for a declaratory judgment of nonliability under

<sup>16</sup> 175 Kan. 473, 264 P.2d 472 (1953), 53 Mich. L. Rev. 149 (1954).

<sup>17</sup> 213 F.2d 200 (8th Cir. 1954).

the policy. In affirming a judgment for the insurer, the court of appeals held that the determination in the personal injury action that Mrs. Bettinger owned the car was not binding on the insurer; that the evidence supported a finding that, while Mrs. Bettinger owned the automobile at the time the policy was issued, she had transferred all her interest to her son prior to the accident; and that the policy was thus avoided for lack of an insurable interest. The court stated: "The contention that the rule of 'insurable interest' has no application to liability insurance is at best a doubtful question of Minnesota insurance law as to which this Court will accept the views of the trial court." It is regrettable that the court in effect denied the injured parties any effective relief on so questionable a basis. Clearly Mrs. Bettinger retained such a relation to the car that its operation by her son could and, in fact, did result in the imposition of a substantial liability. Such an interest should support a liability policy.

*Duty of Liability Insurer to Defend.*—The Supreme Court of Pennsylvania split sharply in defining the duty of a liability insurer to defend in *Wilson v. Maryland Casualty Co.*<sup>18</sup> Wilson, a tavern operator, procured a policy from the defendant, insuring him against "the liability imposed . . . by law for damages . . . because of bodily injury, sickness or disease . . . sustained by any person or persons, caused by accident . . . ." Another clause provided that "Assault and battery shall be deemed an accident unless committed by or at the direction of the insured." The defendant also undertook to defend "any suit against the insured alleging such injury, sickness, disease or destruction and seeking damages on account thereof, even if such suit is groundless, false or fraudulent." One Lees, who was injured in Wilson's tavern, brought action against Wilson to recover damages but the insurer refused to defend. Wilson thereupon settled the claim and then brought suit against the insurer to recover the amount paid Lees. To his complaint Wilson attached a copy of Lees' complaint which alleged that Lees' injuries were caused by Wilson's assaulting him with a blackjack. The insurer made preliminary objections in the nature of a demurrer, and, these being overruled, failed to plead further; whereupon judgment was entered for Wilson. The supreme court reversed the judgment and ordered judgment for the insurer on the ground that the duty of the insurer to defend must be determined from the nature of the claim against the insured. In the instant case, Lees' complaint against Wilson showed a claim based on a willful assault

<sup>18</sup> 377 Pa. 588, 105 A.2d 304 (1954). *Burton v. Travelers Ins. Co.*, 67 N.W.2d 54 (Mich. 1954), involved almost identical facts. With a minimum of discussion the Michigan court held insurer not liable for expenses of defense or the sum paid in settlement of the claim.

and battery by Wilson, a type of liability expressly excluded by the terms of the policy. The insurer was held therefore not to be under a duty to defend the suit or to bear the liability.

The case is interesting chiefly for two vigorous dissenting opinions.<sup>19</sup> The dissenters urged that the insurer was bound to defend the suit unless Wilson had in fact assaulted and battered Lees and that the majority decision accorded the insurer an unwarranted privilege of determining the facts upon which its obligation hinged. The majority view seems sound with respect to the duty to defend. The essential fact upon which that duty rested was not the truth or falsity of the charges against Wilson but the kind of claim made against him. The latter fact was established by Wilson himself when he attached a copy of Lees' complaint to his own.

It is noteworthy however, that Wilson sought to recover the amount that had been paid Lees in settlement and not the costs of defending Lees' suit. If in fact Wilson did not assault Lees, should the insurer have a complete defense merely because of what Lees alleged, or should Wilson, in his action against the insurer to recover the amount paid in settlement, have the privilege of proving that Lees' accusations were false and that the injury in fact resulted from accident? The recent decision of the Court of Appeals for the Ninth Circuit in *Journal Publishing Co. v. General Casualty Co.*<sup>20</sup> held that while the obligation of a liability insurer to defend is determined by the allegations of the complaint against the insured, the insurer's duty to pay on behalf of its insured the damages assessed against him depends on the facts the insured can actually prove in the action against the insurer. Perhaps such a recognition of two separate and distinct duties made immediately performable by different factors would eliminate the sharp division in the Pennsylvania court.

*Contribution between Co-insurers.*—A recurring fact situation involves the issuance of policies covering the same liability by two insurers, *A* and *B*, to the same insured. When a claim is made against the insured and the insurers are requested to assume responsibility for the defense, *A* complies but *B* wrongfully refuses. *A* pays the judgment against the insured and sues *B* to recover an amount determined by reference to the pro-rata clauses in the two policies. Should *A* be regarded as a volunteer in making payments in excess of its pro-rata liability and therefore denied contribution or should *A* be subrogated to the insured's claim against *B* and permitted to recover?

In *Commercial Standard Insurance Co. v. American Employers*

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<sup>19</sup> 377 Pa. 588, 595, 598, 105 A.2d 304, 308, 311 (1954).

<sup>20</sup> 210 F.2d 202 (9th Cir. 1954).

*Insurance Co.*<sup>21</sup> the federal district court followed the first view, but its judgment was reversed by the Court of Appeals for the Sixth Circuit.<sup>22</sup> The court of appeals distinguished between equitable and conventional subrogation and, while reserving judgment as to whether insurer *A* was a volunteer so as to acquire no rights on the basis of equitable subrogation, held that the volunteer rule had no application to conventional subrogation, so that insurer *A* was entitled to enforce the insured's rights against *B* by reason of the subrogation provisions in *A*'s policy. The same view was approved but found inapplicable by the Court of Appeals for the Second Circuit in *Maryland Casualty Co. v. Employers Mutual Liability Insurance Co.*<sup>23</sup> On the other hand the Supreme Court of Michigan in *Detroit Automobile Inter-Insurance Exchange v. Detroit Mutual Automobile Insurance Co.*<sup>24</sup> seems to have rejected the view that the plaintiff insurer was a volunteer in paying more than its pro-rata share and to have required contribution on the basis of equitable subrogation. The latter decision can, however, be rationalized as involving conventional subrogation since the plaintiff insurer's policy did contain a subrogation clause.<sup>25</sup> In view of the fact that the plaintiff insurer's policy will customarily contain a subrogation clause, use of a theory of conventional rather than equitable subrogation will have practical importance in few cases. Nevertheless, the frontal assault made by the Michigan court on the volunteer rule recognizes the realities of the relation among the insured, the injured party, and the two insurers, and therefore seems preferable.

*Insurer's Waiver of Subrogation Rights.*—The Supreme Court of Pennsylvania in *Roberts v. Fireman's Insurance Co.*<sup>26</sup> sustained insured's recovery against the insurer despite his prior release of the person who allegedly caused the loss. The policy covered a building against damage caused by vehicles. In the course of construction of a building on adjacent land, a machine called a high-lift was used in excavating along the wall of insured's building. One end of the building collapsed, fell into the excavation, and killed or injured several persons. Insured notified his insurer of the loss. The latter's adjuster declined to recommend payment, contending that the collapse resulted from faulty construction of the building, not from operation of the

<sup>21</sup> 108 F. Supp. 176 (W.D. Ky. 1952), criticized, 52 Mich. L. Rev. 123 (1953). The volunteer rule was also relied on in *Fireman's Fund Indemnity Co. v. Shelby Mut. Cas. Co.*, 95 Ohio App. 88, 117 N.E.2d 477 (1953).

<sup>22</sup> 209 F.2d 60 (6th Cir. 1954).

<sup>23</sup> 208 F.2d 731 (2d Cir. 1953).

<sup>24</sup> 337 Mich. 50, 59 N.W.2d 80 (1953).

<sup>25</sup> The decision was explained in this way by Judge McAllister in *Commercial Standard Ins. Co. v. American Employer's Ins. Co.*, 209 F.2d 60 (6th Cir. 1954).

<sup>26</sup> 376 Pa. 99, 101 A.2d 747 (1954).

high-lift. Insured sued the excavators and later sued the insurer on his policy. The parties agreed to let the latter suit lie dormant until insured's action against the excavators was concluded. In the meantime, insured and the excavators were sued for damages by or on behalf of the persons injured or killed by the collapse of the building. Insured, fearing that an unfavorable verdict in this action would be *res judicata* of his claim against the excavators, obtained a consolidation of his action against the excavators and one of the death actions which had been called for trial. After a conference the excavators offered to settle insured's action against them for \$6,000. Before insured accepted this proposal, his attorney informed the insurer's adjuster thereof, advising its acceptance. The adjuster refused to have anything to do with the compromise and merely denied liability under the policy. Insured thereupon accepted the settlement offer and released the excavators. In the instant action on the policy the supreme court regarded the jury's verdict as determinative that: (1) a high-lift was a "vehicle" as that term was used in the policy; (2) the collapse of the building was caused by the high-lift; (3) the settlement with the excavators had not completely indemnified insured. The court then held that, in the light of insurer's conduct, insured's settlement with the excavators and consequent cutting off of the insurer's subrogation rights against them did not provide the insurer a defense. A waiver of the insurer's subrogation rights was found in the adjuster's denial of liability under the policy. The court attempted to distinguish a number of earlier Pennsylvania cases which had accorded the insurer's subrogation rights a high degree of protection.<sup>27</sup> Despite such efforts toward reconciliation, the *Roberts* decision appears to effect a real liberalization in favor of the insured.

*Insurance of Vendor and Vendee under Executory Land Contract.*—A novel result was reached in *Vogel v. Northern Assurance Co.*<sup>28</sup> Shank, owner of a house and lot, contracted to sell to Vogel. Later, Shank insured his interest in the property for \$6,000 and Vogel insured his interest for \$12,000. While both policies were in force and the land contract was still executory, fire destroyed the house. Thereafter, Vogel paid the remainder of the purchase price. Shank conveyed the property to Vogel and assigned his claim arising under his fire insurance policy. Vogel sued both insurers to recover the full amount of insurance under each policy. Although all parties admitted that the "actual cash value" of the house at the time of loss was \$12,000, Vogel prevailed and recovered judgments aggregating \$15,000. Vogel's own insurer relied on

<sup>27</sup> See, in particular, *Illinois Automobile Ins. Exchange v. Braun*, 280 Pa. 550, 124 Atl. 691 (1924).

<sup>28</sup> 114 F. Supp. 591 (E.D. Pa. 1953), 102 U. of Pa. L. Rev. 677 (1954). The case is the subject of a student note in 34 B.U.L. Rev. 48 (1954).



the "other insurance" and "pro-rata" clauses in its policy, but the court held them inapplicable since Shank's insurance did not cover the same interest. While Shank had made an actual assignment of his insurance claim to Vogel, the court declared the same result could be reached without assignment in an equitable action to require Shank's insurer to pay him and to compel him to hold the money in trust for Vogel. It is doubtful that current theory really necessitated the \$3,000 windfall to Vogel; the fundamental doctrine that indemnity sets the ceiling on recovery<sup>29</sup> might well have been made controlling.

*Operation of Exclusion Clause.*—The Supreme Court of Mississippi in *Martin v. Motors Insurance Corp.*<sup>30</sup> reaffirmed its view that an exclusion clause provides an insurer no defense, unless there is a causal connection between the breach thereof and the loss. In the instant case, the insured's automobile was destroyed by fire following a highway accident. At the time of the loss the automobile was subject to an undeclared mortgage. The insurer relied upon a clause in the policy providing that "This policy does not apply . . . (b) while the automobile is subject to any bailment, lease, conditional sale, mortgage or other encumbrance not specifically declared and described in the policy." The court held that since the "act of the insured in encumbering the automobile bore no causal relation to its destruction by fire" the loss was not within the exclusion clause.<sup>31</sup>

*Right of Insurer's Liquidator to Unearned Premiums Collected by Broker.*—In *Bohlinger v. Zanger*<sup>32</sup> the Court of Appeals of New York held that the liquidator of an insolvent insurer was entitled to recover only the earned portion of premiums collected by a broker but not remitted to the insurer when the policy was cancelled by the order of liquidation. The lower New York courts had held that the liquidator was entitled to recover all the premiums collected by the broker, relying on Section 121 of the New York Insurance Law which provides that the broker in receiving premiums acts as the agent of the insurer and on Section 125 which fixes on the broker a fiduciary responsibility to his principal for all premiums collected. The majority of the court of appeals, noting the business practice whereby a broker following cancellation of the policy by the insurer remits only the earned portion of

<sup>29</sup> See *Ramsdell v. Insurance Co. of North America*, 197 Wis. 136, 221 N.W. 654 (1928).

<sup>30</sup> 68 So.2d 869 (Miss. 1954).

<sup>31</sup> For a discussion of earlier Mississippi cases, see Appleman, *Insurance Law and Practice*, §§ 3207, 4404 (1947), and footnotes thereto.

<sup>32</sup> 306 N.Y. 228, 117 N.E.2d 338 (1954), affirming in part 280 App. Div. 917, 115 N.Y.S.2d 918 (1st Dep't 1952), which affirmed 202 Misc. 481, 116 N.Y.S.2d 254 (Sup. Ct. 1952). The case is discussed in 54 Col. L. Rev. 638 (1954) and 18 Albany L. Rev. 266 (1954).

the premium less commission and refunds to the insured the unearned amount, declined to distinguish the case where insolvency and liquidation of the insurer effect termination of the policy. Section 125 of the New York Insurance Law, which does not identify the principal to whom the broker owes a fiduciary duty, was held to contemplate a dual agency and fiduciary duty—to the insurer with respect to earned premiums and to the insured with respect to the unearned amount.

The two dissenting judges advanced cogent arguments for the liquidator's recovering the premiums *in toto*.<sup>33</sup> Their point is well taken that under the logic and rationale of the majority's view an insurer could, by cancelling policies, cast upon insureds who had paid full premiums to a broker the risk of his insolvency or misappropriation with respect to premiums not earned at the time these events occur. Such a result is hardly likely though, since happily few courts are so devoted to logical consistency, and the purpose of the New York statutes to place such risks on the insurer is entirely clear. More persuasive is the dissenters' argument that the majority's decision gives some insureds an unwarranted preference over others who have paid their premiums directly to the insurer or whose brokers have remitted premiums at the time the insurer's insolvency intervenes.

*Marine Insurance: Constructive Total Loss.*—The recent decision of the Court of Appeals for the Second Circuit in *Calmar Steamship Corp. v. Scott*<sup>34</sup> applied an interesting extension of the doctrine of constructive total loss. The insured's vessel was damaged in a Japanese air raid in the Southwest Pacific early in 1942. At that time the limited repair facilities in Australia were controlled by the military authorities and for the foreseeable future would be unavailable to private interests. The district court had found that at the time of the loss it was the master's judgment "that it was highly probable that the cost of recovering and repairing the Portmar, if at any time this could be undertaken and accomplished, would exceed the value of the ship"<sup>35</sup> which was \$688,000. The policy contained a marine clause providing that "No recovery for a Constructive Total Loss shall be had hereunder unless the expense of recovering and repairing the vessel shall exceed the insured value," that value being \$860,000.

The court of appeals, in affirming a decree against the insurer for the insured value, held that the purpose of the marine clause was to adopt the 100 per cent rule and to make that percentage applicable to the insured rather than to the repaired value of the ship. The court held further that the clause was applicable only where reliance was placed

<sup>33</sup> 306 N.Y. 228, 235, 117 N.E.2d 338, 341 (1954).

<sup>34</sup> 209 F.2d 852 (2d Cir. 1954), 67 Harv. L. Rev. 1427.

<sup>35</sup> 103 F. Supp. 243, 258 (S.D.N.Y. 1951).

upon the usual rule that there is a constructive total loss if in the judgment of a competent master there is the highest degree of probability that the cost of repair will exceed the appropriate percentage. In addition to the foregoing basis for a finding of constructive total loss, the court held such a finding proper where, as in the instant case, "the ship has become innavigable because of a risk insured against, and . . . it is impossible for the owner, within the time allotted to him to elect whether to abandon, to form any reliable estimate of the prospective expense of her recovery and repair . . . ." <sup>36</sup>

It is difficult to forecast the practical utility of the "impossibility of estimation" rule laid down by the court. Probably in the great majority of cases modern communication and transportation media will easily provide a basis for reasonable estimation of damage within the time allowed the insured for abandonment. One might, however, envisage attempts by insureds, relying on the extended rule, to tender abandonment fairly promptly after losses in remote places rather than to claim an extension of the time for abandonment within which to acquire reliable data concerning the extent of damage.

*Interpretation of Policy Terms.*—Within the year, three decisions interpreted the provision of an automobile policy covering medical expenses of persons injured by accident "while in or upon, entering or alighting from the automobile." In each instance the court's emphasis was upon the "in or upon" language. In a West Virginia case<sup>37</sup> of first impression, the court denied recovery where the car, after the insured jacked up the rear end and removed a damaged tire, slipped off the jack and injured the insured's arm. In a California case<sup>38</sup> recovery was allowed the person who was injured while squatting near the rear wheel with his hands thereon. An Illinois court<sup>39</sup> also sustained a recovery where the insured, after colliding with another car, got out of his automobile, walked to the curb where he exchanged identification and license number with the other driver, and was injured while standing two or three feet in front of his car verifying his license number. In each case the court appeared to regard some physical contact between the injured party and the automobile as the essential test of whether the party was "upon" the car. The first two cases seem to suggest that such contact must exist at the time the injurious force becomes operative. In fact, the West Virginia case denied recovery, although the injury was caused by the slippage of the insured automobile,

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<sup>36</sup> 209 F.2d 852, 854 (2d Cir. 1954).

<sup>37</sup> *Green v. Farm Bureau Mut. Auto Ins. Co.*, 80 S.E.2d 424 (W. Va. 1954).

<sup>38</sup> *Christoffer v. Hartford Acc. & Indemnity Co.*, 123 Cal. App.2d 979, 267 P.2d 887 (Super. Ct., App. Dep't 1954).

<sup>39</sup> *Wolf v. American Cas. Co.*, 2 Ill. App.2d 124, 118 N.E.2d 777 (1954).

because at the time the car slipped the insured had removed his hands from the wheel in order to pick up a block of wood with which to support the axle. Yet, in the Illinois case, where the physical contact rationale appears quite clearly, it seems there was no contact until the car was propelled forward into the insured by another vehicle striking its rear. In result, if not in expression, the West Virginia and Illinois cases are in conflict.

In *Peoples Life Insurance Co. v. Menard*<sup>40</sup> an Indiana appellate court sustained recovery under an accident policy containing typical language where the insured's death was caused by asphyxiation resulting from the lodging in his larynx of some regurgitated food particles. Indiana applies the distinction between "means" and "results," and the court therefore held that injury or death caused by the mechanical action of food was "effected solely and independently of all other causes through external, violent and accidental means." A dissenting judge insisted that while the means were violent and accidental, they were not "external," since the particles when they lodged were going out rather than coming in.

The Supreme Court of Wisconsin in *Quin v. Hoffmann*<sup>41</sup> gave an unfortunately restrictive interpretation to the word "permission" in the omnibus clause of an automobile liability policy. The plaintiffs alleged they were injured when their automobile collided with the insured vehicle while it was being driven by the insured's unlicensed, fifteen-year-old brother with the actual permission of the insured. The policy contained no exclusion clause relating to operation of the automobile by an unlicensed driver, but a Wisconsin statute prohibited any person from permitting a motor vehicle owned or controlled by him to be operated by another in violation of the license requirement. Purporting to be guided only by its concept of public policy, the court held that "permission" as used in the omnibus clause meant legal permission, so that the unlicensed driver was not within the coverage of the omnibus clause. While deterrence of unlicensed driving is desirable, it is extremely doubtful interpretation to read the prohibition of the penal statute into the insurance policy. If the court felt inclined to effectuate broad public policy, it might well have given heed to the desirability of compensating the injured plaintiffs, who, absent insurance, were likely to be left with the doubtful remedy of uncollectible judgments. The court casually disavowed any such purpose behind the statutory omnibus clause, declaring that its purpose was only to afford the additional insured the same protection as the named insured. Even in the light of so limited a purpose, however, the court's interpretation of the term "permission"

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<sup>40</sup> 117 N.E.2d 376 (Ind. App. 1954).

<sup>41</sup> 265 Wis. 636, 62 N.W.2d 423 (1954).

gives little satisfaction since the named insured and his brother remained as defendants in the action after the insurer was discharged and might be subjected to a substantial liability.

In *Simmon v. Iowa Mutual Casualty Co.*<sup>42</sup> the Supreme Court of Illinois held that where the person injured by the insured's operation of a motor vehicle had given reasonable notice of the accident to the insurer, the policy condition requiring notice "by or on behalf of the insured" was met, even though the insured himself gave no notice within the permitted time. While a literal reading of the policy terms casts some doubt on the court's conclusion, the decision seems justifiable since the insurer had the substantive benefit of notice.

The flow of cases dealing with the question whether the Korean conflict was a war within the meaning of war-risk clauses of insurance policies<sup>43</sup> continued during the past year. The Supreme Court of Iowa<sup>44</sup> and a federal district court<sup>45</sup> applying Massachusetts law held that the Korean hostilities were "war" and that the war-exclusion clauses in double-indemnity provisions were operative. Neither court found such ambiguity in the term as to bring into play the canon of interpretation against the insurer. The holdings seem entirely sound in view of the ordinary understanding of the word "war" and of the obvious purpose of the insurers to exclude from coverage the extraordinary risks incident to large scale military operations against the forces of other nations. Thus the Supreme Court of Pennsylvania<sup>46</sup> remains alone in applying a constitutional test of war to the Korean action.

*Unemployment Insurance.*—In two decisions handed down on the same day, the Supreme Court of New Jersey dealt with the right of elderly workers retired on pension to unemployment compensation. In *Campbell Soup Co. v. Board of Review*,<sup>47</sup> the court held that workers who retired as required by a collective bargaining agreement left work involuntarily and were therefore not disqualified for unemployment compensation, thus reversing the decision of the intermediate court which had held that the workers had left "voluntarily without good cause" on the ground that they, through their agent, the union, had voluntarily subscribed to the collective bargaining agreement re-

<sup>42</sup> 3 Ill.2d 318, 121 N.E.2d 509 (1954).

<sup>43</sup> For discussion of the earlier cases see Comment, 52 Mich. L. Rev. 884 (1954); Decisions, 6 Baylor L. Rev. 111 (1953); 42 Geo. L.J. 155 (1953); 42 Geo. L.J. 318 (1954); 2 Kan. L. Rev. 194 (1953); 4 Utah L. Rev. 120 (1954); 7 Vand. L. Rev. 295 (1954).

<sup>44</sup> *Langlas v. Iowa Life Ins. Co.*, 63 N.W.2d 885 (Iowa 1954).

<sup>45</sup> *Gagliormella v. Metropolitan Life Ins. Co.*, 122 F. Supp. 246 (D. Mass. 1954).

<sup>46</sup> See *Harding v. Pennsylvania Mut. Life Ins. Co.*, 373 Pa. 270, 95 A.2d 221 (1953); *Beley v. Pennsylvania Mut. Life Ins. Co.*, 373 Pa. 231, 95 A.2d 202 (1953), 28 N.Y.U.L. Rev. 900.

<sup>47</sup> 13 N.J. 431, 100 A.2d 287 (1953).

quiring such retirement.<sup>48</sup> In *Krauss v. A. & M. Karagheusian, Inc.*<sup>49</sup> the court reversed an award on the ground, *inter alia*, that a worker who had the privilege of continuing on the job if his employer and the union consented but who retired on pension without seeking such consent left work "voluntarily without good cause" and was therefore disqualified for benefits. In each of the foregoing cases, the court, dealing with the eligibility requirement that the worker be attached to an existing labor market for skills of the type he has to offer, declared irrelevant evidence that persons of advanced age found it very difficult to secure jobs. The court said in *Krauss*:

The claimant's age should properly be a consideration upon the issue of his availability only as it relates to his ability to work or is tied to restrictions which materially limit his capacity for employment. . . . The practice of some employers not to hire applicants above certain ages irrespective of their capacity and willingness to do the work the employer has to offer is a voluntary standard and is not embraced in any legal prohibition. It is doubtful that the practice is uniformly followed by all employers in any given labor market area, and suitable job opportunities which the older claimant is qualified to perform may nonetheless exist. In any event, the primary determinant of the existence of the labor market contemplated under the test is that already mentioned, namely, whether there is a market in the geographical area in which the claimant is willing to work for services which he is able to perform.<sup>50</sup>

The Supreme Court of Minnesota had its first occasion in *Swanson v. Minneapolis-Honeywell Regulator Co.*<sup>51</sup> to interpret the term "available for work" in the Minnesota unemployment compensation law. The court held that "a person is not available for work within the meaning of the statute unless he is accessible or attainable for work when suitable work is offered at such hours as are customary in the type of employment to which he is suited." A claimant who previously had been employed on a shift starting at 8 a.m. and who declined work beginning at either 7 or 7:30 a.m., because she could not make satisfactory arrangements for the care of her child at that hour, was held not "available for work." While no issue was raised thereon in the instant case, the court went on to construe the terms "suitable work" and "good cause."

Two recent New York decisions denied unemployment compensation benefits during the off-season to professional athletes.<sup>52</sup> In each

<sup>48</sup> 14 N.J. Super. 311, 94 A.2d 514 (App. Div. 1953), 28 N.Y.U.L. Rev. 1332.

<sup>49</sup> 13 N.J. 447, 100 A.2d 277 (1953). This case and the Campbell Soup Co. decision are discussed briefly in 5 Syracuse L. Rev. 286 (1954).

<sup>50</sup> 13 N.J. 447, 462, 100 A.2d 277, 285 (1953).

<sup>51</sup> 61 N.W.2d 526, 531 (Minn. 1953).

<sup>52</sup> *Matter of Kaftan*, 283 App. Div. 759, 128 N.Y.S.2d 175 (3d Dep't 1954) (basketball player); *Matter of Bell*, 282 App. Div. 624, 126 N.Y.S.2d 115 (3d Dep't 1953) (hockey player).

case the court examined the contract between player and club and found numerous duties, both affirmative and negative, binding the player during the off-season as well as in the period of active play. The claimants were therefore held to be employed on an annual basis rather than "totally unemployed" within the meaning of the unemployment insurance law.

The New York unemployment insurance law provides that where gratuities are received by an employee from persons other than his employer, these shall be included as part of the remuneration paid by the employer and "the value of such gratuities shall be determined by the commissioner." Pursuant to the statutory direction, the commissioner promulgated a rule providing in relevant part that the value of gratuities received by a chambermaid should be equal to the amount certified by her in a statement to her employer and if no certification were made the gratuities should be deemed to be nil. The rule further provided that employers should give notice to their hotel service employees of the certification privilege and of the consequences of their failure to certify. In *Matter of Gold*,<sup>53</sup> claimant, a chambermaid in a hotel operating on the American plan, received substantial gratuities and insisted that these be included in computing her compensation benefits. Her employer had not, however, given her notice of the certification privilege, and she had not certified the value of the gratuities she received. Reversing the judgment of the appellate division, the court of appeals held that the claimant's gratuities should be taken into account on the ground that the commissioner had a statutory duty to ascertain the amount of the gratuities, that the presumption created by the commissioner's rule could not operate unless notice of the certification privilege was given to the employee, and that the commissioner "has not met the fundamental demands of fairness by merely attempting to impose upon employers the duty of giving notice."

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<sup>53</sup> 307 N.Y. 224, 120 N.E.2d 799 (1954), reversing 279 App. Div. 948, 110 N.Y.S.2d 751 (3d Dep't 1952).